The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

July 31, 2019

Steven T. James
House Clerk
State House Room 145
Boston, MA 02133

Michael D. Hurley
Senate Clerk
State House Room 335
Boston, MA 02133

Dear Mr. Clerk,

Pursuant to Chapter 313 of the Acts of 2010, the Massachusetts Department of Public Health is pleased to issue a summary of Calendar Year 2017 activities related to screening for postpartum depression (PPD).

Sincerely,

Monica Bharel, MD, MPH
Commissioner
Department of Public Health

Cc: Representative James O'Day (PPD Legislative Commission Co-Chair)
Senator Joan Lovely (PPD Legislative Commission Co-Chair)

Charles D. Baker
Governor

Karyn Polito
Lieutenant Governor

Marylou Sudders
Secretary

Monica Bharel, MD, MPH
Commissioner

CY17 Summary of Activities Related to Screening for Postpartum Depression

July 2019

Massachusetts Department of Public Health

Legislative Mandate

The following report is hereby issued pursuant to Chapter 313 of the Acts of 2010 as follows:

The Department of Public Health "*shall issue regulations that require providers and carriers to annually submit data on screening for postpartum depression. Following the receipt of data, the commissioner of public health shall issue an annual summary of the activities related to screening for postpartum depression, including best practices and effective screening tools. The department shall annually file the summary with the commissioner of public health and the clerks of the house of representatives and the senate not later than June 30; provided, however, that the first report is due not later than June 30, 2011."*

Introduction

On August 19, 2010, Chapter 313 of the Acts of 2010, An Act Relative to Postpartum Depression, was signed into law. This legislation has two primary components: the establishment of a postpartum depression (PPD) Legislative Commission and a requirement that the Massachusetts Department of Public Health (DPH) promote a culture of awareness, de-stigmatization, and screening for perinatal depression.

Specifically, DPH is charged with:

- Developing standards for effective PPD screening;
- Making recommendations to health plans and health care providers for PPD screening data reporting;
- Issuing regulations that require health plans and health care providers to annually submit data on screening for postpartum depression; and
- Issuing an annual summary of the activities related to screening for postpartum depression including best practices and effective screening tools.

This report provides a summary of activities for Calendar Year 2017.

PPD Regulations - 105 CMR 271.000

An Act Relative to Postpartum Depression, Chapter 313 of the Acts of 2010 charged DPH to issue regulations that require carriers and health care providers to annually submit data on screening for PPD. Understanding statewide PPD screening patterns and outcomes through relevant data reporting to DPH is intended to improve the detection of this prevalent condition and facilitate treatment for mothers in need of help.

The PPD Regulations (105 CMR 271.000) were promulgated in December 2014 and require annual reporting by a provider that conducts or oversees screening for PPD, using a validated screening tool, during a routine clinical appointment in which medical services are provided to a woman who has given

birth within the previous six months. The regulation also applies to a carrier that receives a claim for this PPD screening.

The Providers responsible for adhering to these regulations are OB-GYNs, Family Medicine Practitioners, and Advanced Practice Nurses including Nurse Midwives and Nurse Practitioners, and Physician Assistants, who practice in a family medicine/OBGYN setting.

Providers can report their PPD Screening data to DPH through an annual written report or through claims codes. Data collection began in CY2015. Providers are able to submit an annual written report to DPH by March 1 for the previous calendar year using the "Annual PPD Data Reporting Form" available on the DPH webpage dedicated to PPD at:
http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/postpartum-depression/ppd-regulations-on-screening-reporting-requirements.html

Alternatively, Providers are able to use the HCPCS code of S3005 (Performance Measurement, Evaluation of Patient Self-Assessment, Depression) with a diagnostic range Z39.2 (Routine Postpartum follow up, formerly ICD9 V24 - Screening for Postpartum Depression) and with a modifier as a mechanism for reporting PPD screening.

Servicing Provider	Modifier for use with a positive PPD screen	Modifier for use with a negative PPD screen
OB-GYNs, Family Medicine Practitioners, Advanced Practice Nurses including Nurse Midwifes and Nurse Practitioners, & Physician Assistants	U1	U2

Depending on the private carrier, the service code is set to pay at zero or at $0.01. Private carriers have been accepting this service code from the servicing providers identified above, and are reporting it directly to the All Payer Claims Database (APCD) at the Center for Health Information and Analysis (CHIA) as required under the PPD Regulations. Effective May 16, 2016, MassHealth began paying perinatal care providers for the administration of standardized depression screening during pregnancy and the postpartum period utilizing the above mentioned HCPCS code.

PPD Data Collected through Claims Codes & Linkage with APCD

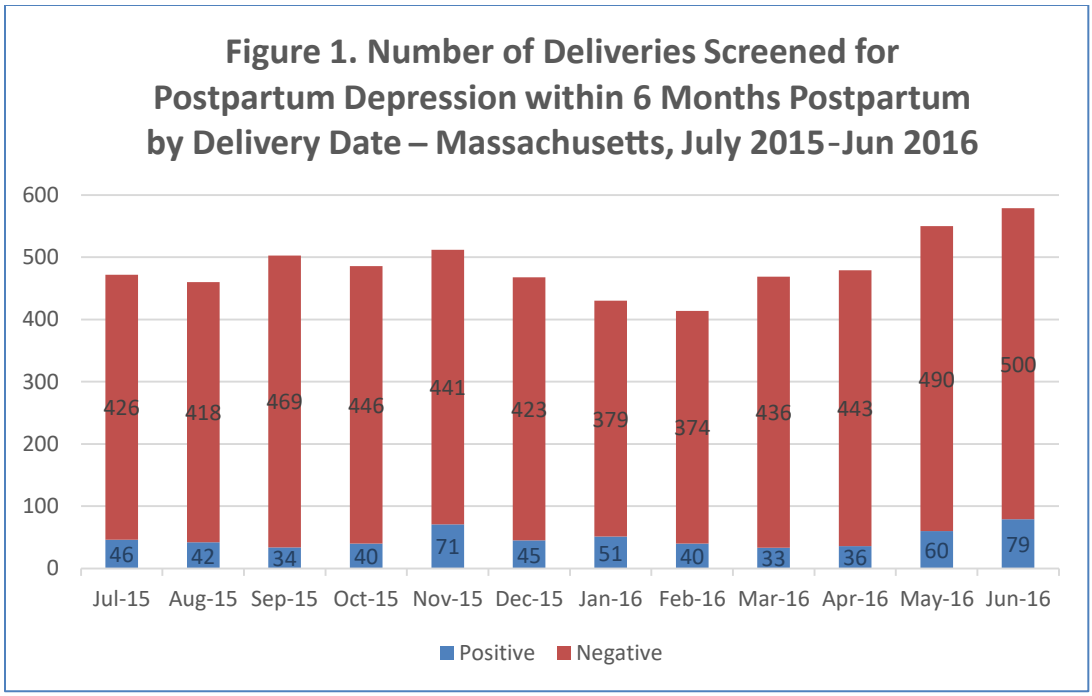
Background: Chapter 313 of the Acts of 2010, An Act Relative to Postpartum Depression, called for submission of data on postpartum depression (PPD) screening to examine the frequency and scope of PPD among new mothers in Massachusetts. PPD defined as depression occurring within 12 months after giving birth, includes feelings of sadness, hopelessness and anhedonia—the loss of interest in previously pleasurable activities. PPD is an important public health issue with profound long-term consequences for mothers and families if left untreated, including impaired mother-infant bonding, delayed social and cognitive development in children, and increased risk of maternal suicide and infant death. It is recognized that greater than 50% of mothers with PPD are not identified and thus do not seek help from a health care or mental health professional.

Methodology: The All Payer Claims Database (APCD) collected by the Center for Health Information and Analysis (CHIA) were linked to the Massachusetts birth certificate data for calendar years 2015 and

2016. In 2017, CHIA initiated a series of changes to the way it collects Personally Identifiable Information (PII) for the APCD. These changes were in response to the recent modifications to the Federal Law protecting the identity of individuals that received substance abuse treatment. They include the obfuscation and in some cases removal of certain patient identifiers at the site of the insurance carrier. They additionally include hashed and in some cases removal of PII housed at CHIA for both current APCD data and previous releases. CHIA has created a new APCD Master Patient Index (MPI) that assigns a single unique surrogate key to each person, regardless of how many different insurance carriers have submitted data about the person. APCD data obfuscation begins by processing Member Eligibility (ME) data through CHIA's data intake application called FileSecure, which is deployed as on-premise software at the data submitter. FileSecure prepares ME data for use in the APCD MPI. All legacy APCD data submitted to CHIA prior to the FileSecure application deployment has been prepared and securely hashed using the exact same logic that FileSecure uses to process newly submitted data. The birth certificate data were also standardized and hashed using the same logic. First name (hashed), last name (hashed), date of birth (hashed), and zip code (5 digit) were used in APCD MPI matching scoring. CHIA's MPI solution employs a probabilistic approach that uses these fields to generate a score that represents how well a record matches to another record. When two records are compared, each field is given a CHIA-assigned weight based on whether the field values being compared agree, disagree, or if either of the fields is empty. Techniques used to accommodate minor variations such as misspellings and digit transpositions cannot be applied to hashed data. The weights from each field comparison are summed to determine the total record score. If the record score exceeds the CHIA-defined threshold, the records are considered a match and are linked together as a single entity (person). Records linked together are assigned a surrogate key known as a Member Enterprise ID, or MEID for short.

Results: During July 2015 through June 2016, there are 70,005 unique deliveries from birth certificate, of which 56,080 (80.1%) were linked to an APCD claim. The numbers of women screened for PPD within 6 months after delivery ranged varied monthly ranging from 374 to 500 (Figure 1). During July 2015 through June 2016, 5,822 (10.4%) out of 56,080 deliveries were screened for PPD and 577 (9.9%) had a positive screen. The proportion of women who were screened for PPD was higher among white non-Hispanic (12.4%) and American Indian (11.3%) compared to 8.7%, 7.5% and 6.4% among Asian, black non-Hispanic and Hispanic, respectively. The proportion of PPD screening was lower among women who were covered by Medicaid compared to others (6.9% vs. 13.0%). A higher proportion of screening was seen among women with higher levels of education and the percentage of screening increased with education level (Table 1).

When we look at the results of screening, Hispanic (12.8%) had higher proportion of positive screen compared to white non-Hispanic (9.5%), Black non-Hispanic (9.4%), and Asian (9.2%). Among Hispanic, the largest proportion of positive screen was seen among Puerto Rican (46/287; 16.0%) which contributed to over 50% of the positive screening cased among Hispanic. Other Hispanic included Dominican (12/118; 10.2%), and Mexican (4/36; 11.1%). Other groups were too small to be reported. The proportion of positive screen was higher among women who were covered by Medicaid compared to those on private insurance (13.4% vs. 8.5%). The proportion of positive screen decreased with increasing education levels (Table 2).



PPD Data Collected through Written Reports

For calendar year 2017, 4 Annual PPD Data Reporting Forms were received, 2 forms from insurance carriers and 2 forms from medical practices. Results from those sites include:

- Both insurance carriers reported no postpartum patient encounters or screens during this time period
- The 2 practices reported screening 965 (94.0%) of 1,027 postpartum patients seen
- One practice reported using the Edinburgh Postnatal Depression Scale (EPDS) and one reported using the Patient Health Questionnaire -9 (PHQ-9) to screen women for PPD.
- Overall, 48 women (5.0%) screened positive for PPD, but the percentage varied between the two sites (4.2% v. 13.9%)

Table 1. Women's Characteristics by Status of PPD Screening, July 2015 -Jun 2016, MA

	Screened			
	No		Yes	
	N	%	N	%
Total	50,258	89.6	5,822	10.4
Race/Ethnicity*				
White NH	29,458	87.6	4,151	12.4
Black NH	5,615	92.5	456	7.5
Hispanic	9,424	93.6	642	6.4
Asian/PI NH	4,381	91.3	415	8.7
American Indian	196	88.7	25	11.3
Other NH	269	91.5	25	8.5
Unknown	906	89.3	108	10.7
Insurance*				
Medicaid	22,314	93.1	1,662	6.9
Other	27944	87.0	4160	13.0
Education*				
<HS	4,971	94.9	267	5.1
HS/GED	8,773	92.2	741	7.8
Some College/Associate Degree	13,637	90.0	1,520	10.0
Bachelor Degree	11,193	87.6	1,580	12.4
Graduate Degrees	10,208	87.3	1,482	12.7
Preterm Birth*				
No	46,277	89.5	5,424	10.5
Yes	3,911	90.8	394	9.2
Plurality				
Singleton	49,345	89.6	5,700	10.4
Multiple	913	88.2	122	11.8
Parity*				
1	21,912	88.9	2,738	11.1
2	16,981	89.1	2,077	10.9
3+	11,285	91.8	1,005	8.2
Married*				
No	19,124	91.6	1,756	8.4
Yes	31,134	88.4	4,066	11.6

* P<0.01

Table 2. Women's Characteristics by Results of PPD Screening, Jul 2015-Jun 2016, MA

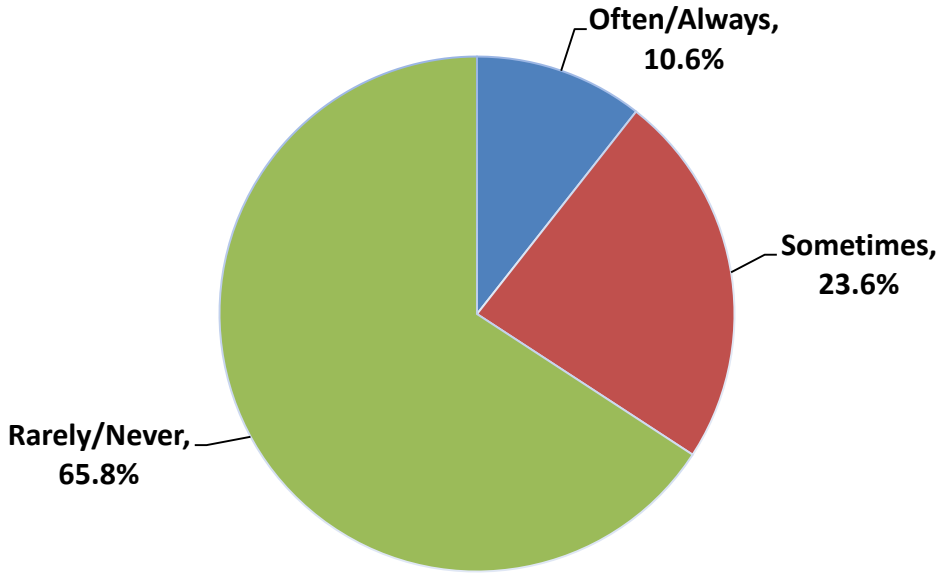
	Screen Results			
	Negative		Positive	
	N	%	N	%
Total	5,245	90.1	577	9.9
Race/Ethnicity				
White NH	3,757	90.5	394	9.5
Black NH	413	90.6	43	9.4
Hispanic	560	87.2	82	12.8
Asian/PI NH	377	90.8	38	9.2
American Indian	21	84.0	4	16.0
Other NH	22	88.0	3	12.0
Unknown	95	88.0	13	12.0
Insurance*				
Medicaid	1,440	86.6	222	13.4
Other	3805	91.5	355	8.5
Education*				
<HS	235	88.0	32	12.0
HS/GED	644	86.9	97	13.1
Some College/Associate Degree	1,334	87.8	186	12.2
Bachelor Degree	1,457	92.2	123	7.8
Graduate Degrees	1,371	92.5	111	7.5
Preterm Birth				
No	4,893	90.2	531	9.8
Yes	348	88.3	46	11.7
Plurality				
Singleton	5,139	90.2	561	9.8
Multiple	106	86.9	16	13.1
Parity				
1	2,470	90.2	268	9.8
2	1,880	90.5	197	9.5
3+	893	88.9	112	11.1
Married *				
No	1,523	86.7	233	13.3
Yes	3,722	91.5	344	8.5

* P<0.01

Pregnancy Risk Assessment Monitoring System (PRAMS)

Since 2007, DPH has monitored the health of women and children in the Commonwealth with the Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS), an ongoing survey of new mothers. The survey asks a set of two questions related to the experience of postpartum depression (PPD). Based on the most recent data available (2015-2016, N=2,609), an estimated 10.6% of mothers in Massachusetts experience PPD symptoms always or often, 23.6% experience PPD symptoms sometimes, and 65.8% experience PPD symptoms rarely or never (Figure 1).

Figure 1. Frequency of self-reported postpartum depressive symptoms, MA PRAMS, 2015-2016



PRAMS data from 2015-2016 suggests some Massachusetts mothers are more likely to report experiencing PPD symptoms. Compared to White non-Hispanic mothers (7.9%), Black non-Hispanic mothers (17.4%) and Asian non-Hispanic mothers (14.8%) were more likely to experience PPD symptoms often or always. Similarly, mothers who are not married (15.0%) have higher prevalence of PPD symptoms compared to mothers who are married (8.3%). Although higher prevalence of PPD symptoms was observed among mothers with less than a high school education (16.2%), high school education (15.8%) and some college education (11.6%) compared to mothers with college education (8.0%), these differences were not statistically significant after adjusting for maternal race/Hispanic ethnicity, nativity and marital status.

Early Intervention Parenting Partnerships (EIPP) – Social Connectedness & PPD Screening

The Massachusetts Early Intervention Parenting Partnerships (EIPP) program is a maternal and newborn screening, assessment, and service system. Implemented in 2003 after a one year planning process by an Expert Working Group, EIPP provides services to participants with an identified maternal or infant risk factor and links them to services to improve health and developmental outcomes. Through a variety of interventions and strategies to foster continuity of care, EIPP works to address the complex physical, emotional, and environmental health needs of pregnant and postpartum participants.

EIPP provides home visiting and group services to over 250 families annually by a maternal child health (MCH) team that includes a MCH nurse, a mental health clinical professional, and a community health worker (CHW). EIPP provides parental and infant health assessment and monitoring; health education and guidance; screening and appropriate referrals; and linkage with WIC and other resources. Programmatic performance measures and parental and infant outcomes range from improved management of alcohol, tobacco and other drugs, improved parenting skills, improved emotional health, increased rates of exclusive breastfeeding, increased attendance at postpartum visits, and improved nutrition.

Data on the 278 EIPP Participants enrolled during CY17 include the following select eligibility criteria (participants may meet more than one):

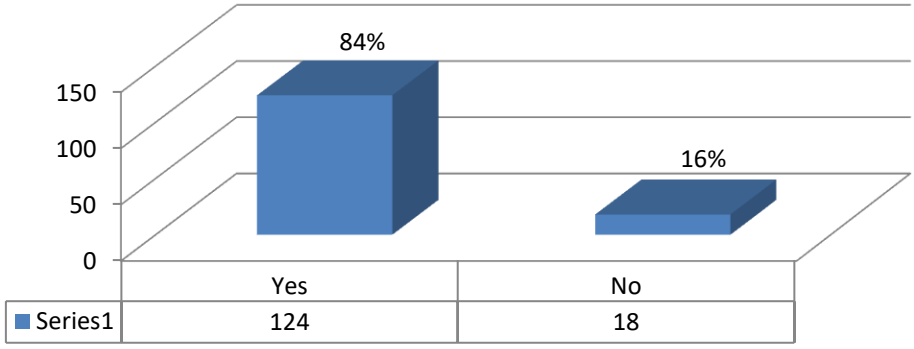
Percent	Eligibility Criteria
82.0%	High level of stress
61.2%	Inadequate food or clothing
51.4%	History of depression including postpartum depression
39.6%	Homelessness or housing instability
15.1%	Tobacco use
7.9%	Substance abuse in the home
3.2%	Violence in the home

At enrollment and at key stages of program engagement, all EIPP participants receive a Comprehensive Health Assessment (CHA) that assesses the social, emotional and physical well-being of the participant and infant in the context of their family. This CHA includes both a Social Connectedness utilizing a three question survey and a PPD screen utilizing the Edinburgh Postnatal Depression Scale (EPDS).

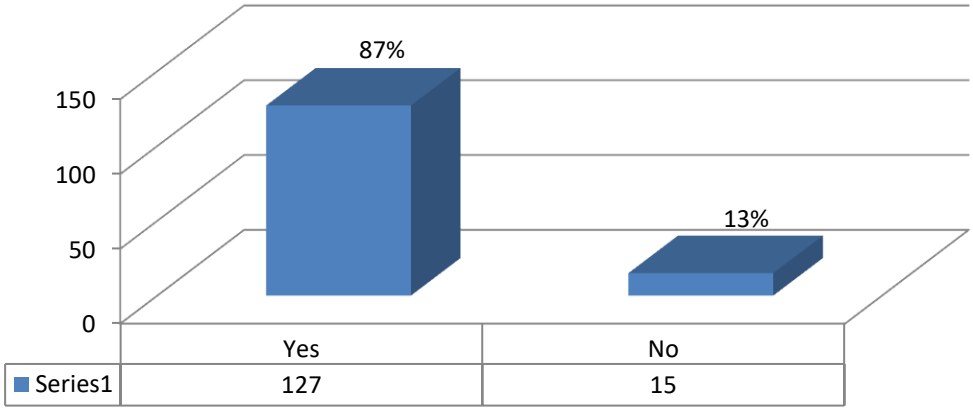
Participants who screen positive for depression are then supported in accessing mental health services including counseling and support groups. In 2017, 100% of the EIPP participants identified with depression and/or a mental health disorder were connected to mental health services. Barriers to accessing mental health services included language, stigma, transportation, and lack of insurance for undocumented participants.

In calendar year 2017, the results of a Social Connectedness Screen and a PPD Screen at 2 months postpartum are below:

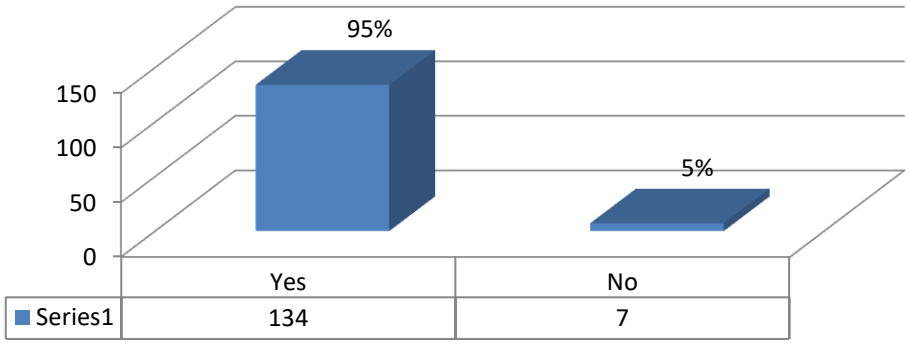
Two Month Postpartum Social Connectedness Screen Q1: Do you feel that you are getting the support you need from others? (N=142)



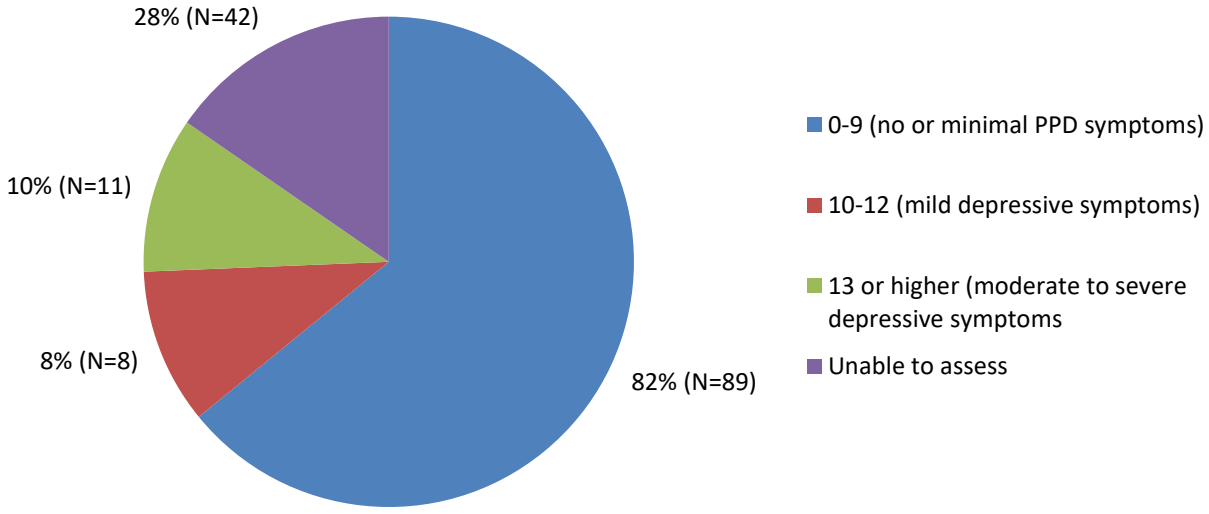
Two Month Postpartum Social Connectedness Screen Q2: Do you have someone to call when you need someone to care for the baby? (N=142)



Two Month Postpartum Social Connectedness Screen Q3: Do you have someone you can count on to listen to you when you need to talk? (N=141)



Score Results of a EPDS Screen conducted at 2 Months Postpartum on EIPP Participants (N=150)



Massachusetts Maternal Mortality & Morbidity Review Initiative

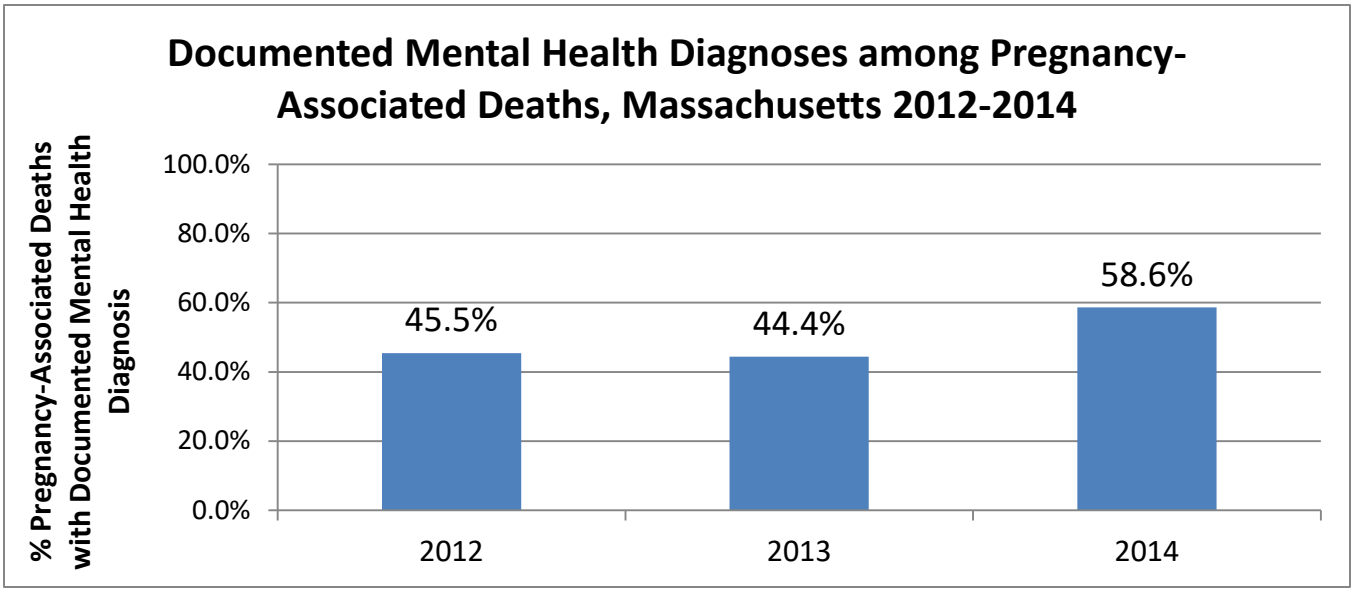
Maternal death, a sentinel event, has dramatically decreased in Massachusetts over the last century. There is a long history of reviewing maternal deaths in Massachusetts which began as a systematic effort in 1941 when the Committee on Maternal Welfare of the Massachusetts Medical Society initiated case reviews of maternal deaths with the goal of improving maternal health.

Since 1997, the Massachusetts Department of Public Health (DPH) has convened the Maternal Mortality and Morbidity Review Committee (MMMRC) to review maternal deaths, study the incidence of pregnancy complications, make recommendations to improve maternal outcomes, and eliminate preventable maternal death. Understanding the causes of these deaths provides insight into the factors that contributed to both maternal morbidity and mortality, which can inform strategies to reduce the incidence of these tragic events.

In the fall of 2017, the Massachusetts Maternal Mortality & Morbidity Review Initiative released a data brief on the documented mental health diagnoses among pregnancy-associated deaths occurring in 2012-2014. The full data brief can be viewed at: https://www.mass.gov/service-details/maternal-mortality-and-morbidity-initiative

Summary of Mental Health Data Brief:
Pregnancy-associated mortality, the death of a woman while pregnant or within one year of termination of pregnancy, irrespective of cause, increased 33% in Massachusetts from 30.4 deaths/ 100,000 live births in 2012 to 40.4 deaths per 100,000 live births in 2014. Pregnancy-associated mortality ratios have been historically low in Massachusetts. This increase in the number of deaths along with the outcomes of Committee reviews was concerning and prompted the Massachusetts Maternal Mortality and Morbidity Review Committee (MMMMRC) to examine the incidence of mental health diagnosis among pregnancy-associated deaths during 2012-2014. The MMMMRC abstracted and reviewed all 69 pregnancy-associated death files from 2012-2014, including information from birth records, death records, additional medical records, police reports and social media sites.

- **More than half (50.7% (35/69)) of pregnancy-associated deaths had a documented mental health diagnosis**
- **The majority (91.4% (32/35)) of mental health diagnoses were documented prior to delivery**



- **The most common mental health diagnoses were depressive disorder, 57.1% (20/35), and anxiety disorder, 51.4% (18/35)**

Most Common Mental Health Diagnoses	N	%
Depressive Disorder	20	57.1
Anxiety Disorder	18	51.4
History of Postpartum Depression in Prior Pregnancy	6	17.1
Posttraumatic Stress Disorder	6	17.1
Bipolar Disorder	6	17.1

During 2012–2014 in Massachusetts, documentation of at least one mental health diagnosis was identified through record abstraction in over half of all pregnancy-associated deaths. In a majority of cases, mental health diagnoses were present before delivery, indicating opportunities for intervention by prenatal and primary care providers. Depressive and anxiety disorders were the most common mental health diagnoses. Maternal depressive disorder can have adverse effects on maternal health and child development, including reduced maternal-infant attachment, sleep disruption, recurring and intrusive negative thoughts, suicidal ideation, and increased substance use. Factors that can place mothers at risk for maternal depression include prior history of depression, family history of depression, hormonal changes experienced during pregnancy, genetics, domestic violence, poor environment (e.g., food insecurity, poor housing conditions, lack of financial supports, uninvolved husband or partner), and the absence of a community network.

This mental health data brief was disseminated widely to obstetric and primary care providers serving pregnant and postpartum women in order to raise the level of awareness about this important health issue and promote universal postpartum depression screening among providers. .

Massachusetts Home Visiting Initiative (MHVI)

Since the spring of 2010, DPH has been implementing the Maternal, Infant, and Early Childhood Home Visiting Program, a federally funded program for states, tribes, and territories to develop and implement one or more evidence-based maternal, infant, and early childhood home visiting model(s). Massachusetts' program is known as the MA Home Visiting Initiative (MHVI).

In September 2017 DPH was awarded $6.8 million in federal funds, marking the seventh year of funding. MHVI funds evidenced-based home visiting programs including Parents as Teachers, Early Head Start, and Healthy Families America. Depression screening is conducted with all program participants and data are ~~is~~ analyzed for all 24 home visiting programs on a quarterly basis and with the annual report to the federal funding agency, the Health Resources and Services Administration (HRSA), each October. Screens are conducted within three months of enrollment and updated in compliance with model fidelity. In federal FY17, 83% of expected screenings for depressive symptoms were completed within three months of enrollment.

Welcome Family

The Welcome Family program offers a universal, one-time nurse home visit to mothers with newborns and their families, regardless of age, income, or other criteria in five Massachusetts communities. The goal of Welcome Family is to promote optimal maternal and infant physical and mental well-being and provide an entry point into a system of care for families with newborns in Massachusetts. The visit is conducted within 8 weeks postpartum, lasts approximately 90 minutes, and is conducted by a nurse with maternal and child health experience. All services are provided at no cost to families. The primary focus of Welcome Family is the mother and her newborn, but any caregiver is eligible for a visit, including fathers, grandparents, adoptive, and foster parents.

During the visit, the Welcome Family nurse assesses the following six areas. Each area includes screening, brief intervention, education, and referrals to services as needed.

- Maternal emotional health, including a depression screen
- Maternal and infant nutrition, including breastfeeding
- Unmet health needs
- Intimate partner violence
- Substance use
- Maternal and infant clinical assessment

The nurse also spends time addressing the family's questions or concerns. Participants receive a Welcome Family bag with gifts and information to support mom and baby. In addition, participants receive a follow-up phone call to inquire about the outcome of the referrals made during the visit and assess the need for any additional referrals.

Marketing and outreach activities are conducted at the community level to identify and recruit mothers with newborns. Relationships are fostered with potential referral sources in the community including birth hospitals, OB-GYNs, midwives, pediatricians, and WIC.

Welcome Family is available to families living or giving birth in five communities: Fall River, Boston, Lowell, Holyoke, and Springfield. During 2017, 1,957 PPD depression screens were offered during Welcome Family visits. There were 342 positive PPD screens, of which 170 received a referral to services. Families who did not receive a referral received brief interventions by the Welcome Family Nurse if the family declined a referral.

> *"I had some concerns about postpartum depression and being able to talk to the nurse about it helped a lot. I had never had postpartum depression previously so it was helpful to learn more about it from the nurse."-Welcome Family Participant*

Additional Activities and Products

In CY17, additional activities were conducted and products were developed with the goal of supporting health care providers and health plans as DPH collaboratively implements the PPD Legislation.

1. In partnership with the PPD Legislative Commission subcommittee focused on community resources, DPH finalized updates to the web page dedicated to PPD on the DPH website with additional resources. It can be viewed at: https://www.mass.gov/postpartum-depression

2. At the request of the Department of Children and Families (DCF), DPH continues to provide quarterly PPD trainings to DCF social workers at their training center in Southborough.

3. At the request of the Hampden County PPD Task Force, DPH conducted a PPD presentation on January 18, 2017 at Baystate Medical Center in Springfield.

4. At the request of the Department of Corrections, DPH conducted a PPD Presentation to Massachusetts Sheriffs on January 25, 2017.

5. At the request of the Massachusetts Home Visiting Initiative, DPH conducted PPD training on July 10, 2017 at the WIC Learning Center in Framingham.

6. At the request of the PPD Legislative Commission, DPH conducted a PPD Presentation to the members of the PPD Legislative Commission on October 11, 2017 at the State House.

7. At the request of HRSA, DPH conducted a presentation entitled "Promoting Perinatal Mental Health: The Massachusetts Experience" at the HRSA/MCHB Technical Assistance Meeting on October 18, 2017 in Rockland, Maryland.

8. DPH worked collaboratively with the Department of Corrections on developing Standards of Care for pregnant inmates that include a provision requiring PPD screening as required under the *Act to Prevent Shackling and Promote Safe Pregnancies for Female Inmates* signed into law in 2014.

9. DPH secured funding to reproduce the brochure entitled "Being a Mother is Hard Job." This brochure is available for free to Massachusetts residents and health care providers and can be

ordered through the Massachusetts Health Promotion Clearinghouse at http://massclearinghouse.ehs.state.ma.us/category/CHILD.html

10. In collaboration with Judge Baker Children's Services, DPH has worked to assess, define, and standardize the EIPP model across all vendor sites. The process is expected to be complete on June 30, 2018.

11. DPH secured funding to evaluate the EIPP model over the next three years. DPH solicited bids for a qualified vendor during the spring of 2018 and the contract will be awarded in May with a start date of July 1, 2018.

12. DPH participated in the quarterly PPD Legislative Commission Meetings and the annual PPD Awareness Day event at the State House.

13. DPH Maternal Mortality & Morbidity Review Initiative plans to publish a Bulletin on maternal mortality and substance use in CY2018.

Planned Next Steps

During the next calendar year, DPH plans to:

1. At the request of the Boston Public Health Commission, a presentation on maternal mental health and maternal mortality in Massachusetts was conducted by DPH on February 22, 2018.
2. Continue to offer and conduct training to DCF Social Workers on PPD and the impact of infant development at their training center.
3. Continue to provide training and technical assistance to providers and carriers on the PPD Regulations requiring annual reporting of data on screening for PPD.
4. Continue to work with the All Payers Claim Database (APCD) at Center for Health Information and Analysis (CHIA) to collect the specific data elements from insurance claims with the service code S3005 attached and support the mechanism for CHIA to share this PPD Screening data with DPH who can then analyze and report to the Legislature as required under the PPD Legislation.
5. Support the recently funded PPD Pilot Programs at the three Community Health Centers in implementing universal PPD screening at their sites.
6. Continue to participate in the quarterly PPD Legislative Commission Meetings.
7. Continue to manage current EIPP contracts, ensure the provision of ongoing training, conduct periodic site visits with approved vendors to ensure program fidelity, and evaluate program effectiveness in identification of need and referral into services.
8. Continue MHVI and Welcome Family service provision to ensure ongoing training, conduct periodic site visits with approved vendors to ensure program fidelity, and evaluate program effectiveness in identification of need and referral to services.